DEPARTMENT OF HEALTH SERVICES
714/744 P Street
P. O. Box 942732
Sacramento, CA 94234-7320
(916) 654-8076

Date: December 29, 1999

To: Administrators

Subject: Final Draft Policy Letter on Quality Assessment and Performance Improvement

Enclosed is the final draft of the Medi-Cal Managed Care Division's (MMCD) Quality Assurance and Performance Improvement policy letter. The Medical Director's Quality Improvement (QI) workgroup assisted with the development of this letter, and we sincerely appreciate the considerable time and effort the workgroup expended on this final draft policy letter. This final draft policy letter is submitted to you as a guide to the development of your quality improvement program. When the contract amendments for quality assessment and performance improvement are completed, we will release the final policy letter. The final policy letter will not be different from the enclosed final draft policy letter.

If you have questions, please call Ms. Melba Hinojosa, at (916) 654-0748 or e-mail mhinojos@dhs.ca.gov.

Sincerely,

Judith K. Phelps Jr.

Mary Fermazin, M.D., M.P.A., Chief
Office of Clinical Standards and Quality

Enclosure

STATE OF CALIFORNIA-HEALTH AND HUMAN SERVICES AGENCY

GRAY DAVIS, Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P Street
P. O. Box 942732
Sacramento, CA 94234-7320
(916) 654-8076

FINAL DRAFT

MMCD Policy Letter No. 99-

TO:
[ ] Primary Care Case Management Plans
[ ] Prepaid Health Plans
[X] Two-Plan Model Plans
[X] County Organized Health Systems
[X] Geographic Managed Care Plans

SUBJECT: QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM

PURPOSE

To provide clarification regarding Medi-Cal Managed Care Plans' (hereafter referred to as Plans) contract responsibilities relating to the Quality Assessment and Performance Improvement Program.

BACKGROUND

Section 1932(c)(1) of the Social Security Act, added by section 4705(a) of the 1997 Balanced Budget Act (BBA), requires States entering into contracts with the Plans under SSA section 1903(m) to develop and implement a quality assessment and improvement strategy. At a minimum, these strategies must include: 1) access standards; 2) measures that examine other aspects of care and services directly related to improving the quality of care (e.g., grievance procedures and marketing standards); 3) procedures for monitoring and evaluating the quality and appropriateness of care and services that Medicaid enrollees receive; and 4) requirements for the provision of data (e.g. Health Plan Employer Data and Information Set/HEDIS).

The Quality Improvement System for Managed Care (QISMC) is a set of guidelines for State Medicaid agencies to use in complying with the above statute. It defines a uniform set of quality standards in initial and ongoing review of Plans with a Medicaid contract. In July 1998, the Department of Health Services (DHS) convened a Quality Improvement (QI) Workgroup consisting of Plan Medical Directors, Chief Executive Officers, and other Plan staff. This Workgroup has been focusing on one of the QISMC domains, which pertains to quality assessment and performance improvement. This policy letter is based on the Workgroup's recommendations regarding changes to existing quality improvement contract requirements necessary to comply with the 1997 BBA and the QISMC guidelines.

POLICY

Effective January 1, 1999, Plans must comply with requirements for external reporting of performance measurement results (External Accountability Set), conduct a joint Quality Improvement Collaborative Initiative (QICI), and conduct Internal Quality Improvement Projects (IQIPs) as outlined in this policy letter. This policy letter clarifies the newly amended contract requirements regarding Quality of Care Studies. Enclosed in this letter are the summaries of the requirements for these policy issues (Enclosure A).

I. EXTERNAL ACCOUNTABILITY SET

Plans are required to report the External Accountability Set after completing a calendar year of operation under their initial contract with DHS. Plans must report audited results on at least the seven HEDIS measures selected by DHS as the External Accountability Set. "Audited" means a National Committee for Quality Assurance (NCQA) Licensed Audit Organization performed the HEDIS audit according to NCQA's auditing program guidelines. Plans must adhere to the latest version of HEDIS specifications that are applicable to the reporting period and to DHS timelines. Generally, Plans will be required to report audited HEDIS results by June 15 of each year. For 2000, Plans will be granted an extension and be allowed to report audited HEDIS results to DHS by September 1, 1999.

DHS' preference is for the use of a single audit organization to ensure consistency between Plan audits and improve communication between the audit organization, the Plans, and DHS. Plans audited by Health Services Advisory Group (HSAG) in 1999 must continue to do so.

A. <u>NCQA-Licensed Audit Organizations</u>

The DHS contracted External Quality Review Organization (EQRO), a National Committee for Quality Assurance (NCQA)-Licensed Audit Organization, will conduct the HEDIS compliance audit on all Plans at no cost, except for Plans which had already contracted with another NCQA-Licensed Audit Organization in late 1998. The Plans that have contracted with another NCQA-Licensed Audit Organization in 1998, will do so at their own cost.. These Plans must do the following:

- Submit the name of the NCQA-Licensed Audit Organization they intend to use by January 15th of each year.
- Submit the initial HEDIS Compliance Audit Report upon completion by the NCQA-Licensed Audit Organization.
- Submit the Final HEDIS Compliance Audit Report within DHS' specified timeline.

DHS reserves the right to request additional information regarding the audit process as determined by the Department.

B. Measures

For Two Plan Model Plans (both the commercial and local initiative) and the Geographic Managed Care Plans, the external accountability set for 1999 consists of the following seven HEDIS measures:

- Childhood Immunization Status (for 2 year olds)
- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life
- Adolescent Well-Care Visits
- Initiation of Prenatal Care
- Prenatal Care in the First Trimester
- Check-Ups After Delivery

The County Organized Health Systems (COHS) must report on the same set of measures with the exception of Well Child Visits (3, 4, 5, and 6 years of life), which is replaced with Eye Exams for People with Diabetes.

Beginning 2001, some of the HEDIS measures may be replaced by new HEDIS measures as these are developed or as measures are retired. The QI Workgroup may recommend new replacement measures and DHS will make the final determination on these measures.

C. Measurement Period

The measurement period for the External Accountability Set will be based upon the prior calendar year or as specified by the latest version of HEDIS. Data collected must be abstracted from the Plan's service delivery activities during the measurement period, except under certain circumstances. An example of this exception might be a health plan that is not capitated for Child Health Disability Prevention Program services, and therefore it might be necessary for the Plan to obtain data from other entities such as DHS.

D. Minimum Performance Levels (MPLs)

Beginning in year 2000, Plans must meet or exceed the DHS established minimum performance levels (MPLs) for each of the HEDIS measures. DHS will solicit input from the QI Workgroup before establishing the MPLs. If Plans do not meet the MPL or reports a "Not Report" (NR) due to an audit failure on a specific measure, it must develop strategies to improve the performance level. DHS reserves the right to sanction Plans which consistently (***more than two years)*** fail to achieve a MPL or which consistently receive an "NR" designation on one or more HEDIS measures. This sanction will be consistent with the sanction specifications in the DHS' health plan contract and applicable regulations.

E. Sampling Method

Plans must calculate HEDIS measures for each contract held with DHS. The audited contract-specific HEDIS rates submitted to DHS must be based on a sample that has representation from each county covered under the Plan's contract. The required sampling method for the contracts covering multiple counties will be proportional sampling (Enclosure B).

F. Improvement Strategies

If the audited HEDIS measures do not meet the MPL, Plans must analyze the data, identify potential causes and/or barriers to improvement, and implement interventions. In general, these interventions should directly remove obstacles to improvement, increase incentives for improvement, or leverage any forces that appear to be causing improvement, and target a specific population.

DHS expects Plans to implement improvement strategies as expediently as possible for those measures that do not meet MPL or are reported as "NR" due to audit failure. Plans' quality improvement strategy must be filed with DHS within twelve weeks after the HEDIS measure is reported; DHS will acknowledge receipt within one week. DHS will offer limited technical assistance to Plans regarding their improvement strategies and monitor Plans' implementation of these strategies.

II. QUALITY IMPROVEMENT COLLABORATIVE INITIATIVE (QICI)

Plans must undertake a joint Quality Improvement Collaborative Initiative addressing a common topic; topics are subject to change on an annual basis. All participating health plans must use a standardized methodology, as well as quality indicators jointly reviewed and approved by DHS and participating Plans. The collaborative initiative must be completed and reported to DHS in accordance with a timeline specified by DHS after taking into consideration QI Workgroup recommendations. For 1999, exemption from participation from the QICI may only occur when the initial contract start date is later than the beginning of the measurement period.

III. DHS REPORTING

DHS will publicly report the External Accountability HEDIS Set and the joint Quality Improvement Collaborative Initiative (QICI) study results. The purpose of this public reporting is to increase Plan accountability, stimulate Plan internal quality improvement, and provide members with information to make informed choices.

IV. INTERNAL QUALITY IMPROVEMENT PROJECTS (IQIPs)

IQIPs are internal quality improvement projects intended to be used by Plans for their own internal quality improvement purposes. A Plan must conduct clinical and non-clinical IQIPs to measure its own performance in areas where the need for improvement has been identified. The Plan must also undertake systematic interventions to improve performance and evaluate the effectiveness of the interventions. The IQIPs provide an opportunity to use data collection, measurement and analysis to continuously improve the care and service provided to Plan members.

If a health plan has multiple contracts with DHS, it may select the same topic and methodology for each of their contracts. Adequate representation with proportional sampling of each county covered by the contract is required for each project. Each IQIP must have at least <u>two</u> quality indicators. Plans are not required to use HEDIS indicator specifications for the projects; however, DHS expects Plans to follow their chosen and DHS approved methodology and indicators throughout their project(s). DHS must approve methodological refinements within 45 days before the Plan's implementation of the IQIP.

Each IQIP is expected to follow specific phases of progress. While there is no specific timeline as to when these phases are to be completed by Plans, generally an IQIP will follow a four-year cycle for completion.

Definitions for the IQIP's initial report, four phase reports, and the final report are as follows:

- Initial Report: Include information about the purpose and feasibility of the proposed project.
- Phase One Report: Include research design, methodology and project timeline.
- Phase Two Report: Include collection of baseline data.
- Phase Three Report: Include analysis and design of interventions based on baseline data.
- Phase Four Report: Include re-measurement showing significant improvement after interventions have been implemented.
- Final Report: Second re-measurement indicates achievement of sustained improvement.

A. <u>Number of IQIPs</u>

At any one time, Plans must perform a minimum of four and a maximum of six IQIPs. Half of these projects must be clinical in subject matter; the other half of the projects must be non-clinical. Beginning 2001, Plans must initiate an additional new project per year, with the maximum number of required

projects being six in one given year. The topic of the new projects initiated per year must alternate between clinical and non-clinical. DHS strongly encourages Plans to have a comprehensive and effective internal QI program.

B. IQIP Topics and Restriction of IQIP Topics at Any Phase
Each IQIP topic must be systematically selected and prioritized to achieve the maximum benefits for the Plans' members. Of the initial four IQIPs, two must pertain to clinical topics and the other two must pertain to non-clinical topics.

The clinical topics must pertain to the care of, as well as, the primary, secondary, and/or tertiary prevention of both acute and chronic conditions. The non-clinical topics must pertain to the quality of health services delivery (e.g., availability and accessibility, cultural competency, interpersonal aspects of care; the quality of provider/patient encounters; appeals; grievances and other complaints; or focus on the Consumer Assessment of Health Plans Study results (when available) and must have a direct or indirect impact on the health of Plan members.

DHS reserves the right to require the Contractor to focus on a specific subject (clinical or non-clinical) for an Internal Quality Improvement Project.

Only one of the clinical IQIPs may be based on the current External Accountability Set of HEDIS measures. However, it is acceptable for Plans to have clinical IQIPs based on HEDIS measures other than the current External Accountability Set. Such clinical IQIPs may continue even if the HEDIS measure later becomes a HEDIS measure in the External Accountability Set. Only one of the non-clinical IQIPs may address the Consumer Assessment Health Plan Survey results.

C. Existing Internal Quality of Care Studies
Plans may designate existing internal quality of care studies as one or all of the four IQIPs required provided these studies have not progressed beyond phase two and are approved by DHS. Plans must identify these studies in the initial report. (See III. F).

D. Significant Improvement
Plans must demonstrate, through repeated measurement of the quality indicators selected for each IQIP, that there is meaningful improvement in performance relative to the baseline (established by the first reporting year results). Significant improvement is defined as a reduction of the performance gap, which is further defined by a reduction of at least ten percent in the number of members who do not achieve the desired outcome. Significant improvement can also be defined as demonstrating that an improvement measured is significant with a "p" value of less than 0.10.

Although Plans with multiple contracts may select the same IQIP topics, measurable improvement must be determined at the contract level. The repeat measurement must use the same methodology used to establish the baseline measurement. For example, if a Plan used an administrative data set in their initial baseline assessment, it would be restricted to that same data set for remeasurement. If Plans used the hybrid method for their initial baseline measurement, then they must use the same hybrid method for remeasurement.

E. Sustained Improvement

Plans must demonstrate sustained improvement for at least one of the quality indicators in an IQIP. Sustained improvement is defined as documented significant improvement over original baseline performance levels for at least one year after the improvement in performance is first achieved. Sustained improvement is documented through the continued measurement of quality indicators for at least one year after the performance level has improved with the initiation of the IQIP. The re-measurement of each IQIP must show sustained improvement as a result of the Plan's interventions.

Once sustained improvement for at least one of the quality indicators in an IQIP has been achieved , a Plan may drop that IQIP after obtaining approval from DHS. If a Plan is unable to achieve sustained improvement with one or more of their IQIPs and has demonstrated good-faith efforts, DHS may allow the Plan to terminate the project and initiate a new IQIP.

Example: Linear Graph for IQIP Progression[1]

Baseline Measurement	Intervention Period	1st Re-measurement	2nd Re-measurement
Year 1	Year 2	Year 3	Year 4
		This period should show significant improvement over the baseline measurement.	This period must show sustained significant improvement over the baseline measurement.

F. IQIP Reporting

Each plan must submit initial reports on the four IQIPs no later than October 1, 1999[2]. DHS, in consultation with EQRO, will approve all initial reports no later than November 1, 1999. Unapproved IQIPs, or approval withheld pending changes, must be resubmitted to DHS within thirty (30) calendar days of DHS/EQRO notification to Plans. Plans are encouraged to submit their reports early and DHS reserves the right to apply sanctions for late submissions. Subsequent IQIPs must be submitted in accordance with the timelines specified by DHS.

Depending on applicability, Plans must submit a phase completion report to DHS at the completion of each study phase, or a progress report on an annual basis. These reports give both the DHS and EQRO the ability to monitor Plans' progress and offer limited technical assistance when necessary. If Plans are unable to complete a study phase in a given year, they must submit an annual progress report. A progress report is due twelve months after the previous report submission.

Plans must concurrently submit all IQIP reports and all related materials to the Chief of the Office of Clinical Standards and Quality and to the EQRO Contractor.

[1] IQIP study length may vary depending on the chosen topic and its complexity.
[2] San Diego Geographic Managed Care (GMC) Plans may submit their initial reports by November 1, 1999.

Summary Table of First IQIP Reporting Cycle

Reports and Phases	Key Reporting Elements	Date Due
Initial Report	1-6	10-1-99 (San Diego GMC Plans may submit by 11-1-99)
Phase One Report	1-8	12-1-99
Phase Two Report	1-9	Phase completion report or annual progress report*
Phase Three Report	1-13	Phase completion report or annual progress report*
Phase Four Report	1-14	Phase completion report or annual progress report*
Final Report	1-15	Phase completion report or annual progress report*

*Progress reports are to be submitted if the phase extends beyond a twelve month period. Otherwise, a phase completion report will suffice.

Plans must address all key elements for the particular phase report of the project. All fifteen key reporting elements must be addressed in the final report. Plans may use a format of their choice as long as all appropriate key elements are addressed in accordance with Enclosure C, "Components of an Internal Quality Improvement Project".

G. IQIP Key Reporting Elements

Each proposed project must include or address, at a minimum, two quality indicators and the following key reporting elements:

1) Clinical/Non-Clinical Project Designation
2) Project Name
3) Project Questions/Hypotheses
4) Background and Purpose of Project, including Justification/Project Feasibility
5) Clinical Description and Related Clinical Guidelines
6) Performance Goals or Benchmarks for each Quality Indicator
7) Project Timeline (Workplan)
8) Research Design/Project Methodology
9) Data Collection
10) Data Analysis
11) Comparative Analysis
12) Interpretation of Findings
13) Action/Improvement Plan.
14) Re-measurement Data Analysis
15) Second Re-measurement Analysis to Reflect Sustained Improvement

H. IQIP Project Termination

All IQIP termination requests must be submitted to DHS for approval. Under the following circumstances, the Plan may submit a request to DHS for approval to terminate an IQIP:

- The IQIP has achieved significant and sustained improvement for two years.
- Plan wishes to abandon an IQIP due to extenuating circumstances. Plans must include the rationale for abandonment of an IQIP.
- The Plan has demonstrated good-faith efforts.

I. IQIP Technical Assistance

Any Plan seeking limited technical assistance from the EQRO must submit a written request to the DHS/EQRO Project Coordinator. The written request should specify what limited technical assistance is needed. If the Plan chooses to use one of the External Accountability Set measures as the basis for one of their IQIPs, and the EQRO is being utilized by the Plan as the licensed HEDIS auditor, the EQRO can not offer technical assistance related to that particular External Accountability Set measure.

J. Evaluation of IQIPs:

DHS and HSAG will evaluate each IQIP to determine if each project has included two quality indicators and all the key reporting elements as stated in "IV-G" above as well as the following:

- **Timeliness** of each project task and phase.
- **Quantity** is defined as meeting the minimum number of clinical and non-clinical projects required under the contract.
- **Quality** means that each key element meets EQRO/DHS standards. The standards are derived from the sources in Enclosures B and D.
- **Sustained Improvement** is defined as documented significant improvement over original baseline performance levels for at least one yea after the improvement in performance is first achieved. Sustained improvement is documented through the continued measurement of quality indicators for at least one year after the performance level improved following the initiation of the IQIP.

V. PERFORMANCE MEASUREMENT

A. Plan Performance. DHS will recognize plans which achieve excellent performance in the Plan's External Accountability Set, the QICI, the IQIPs, annual audits and other areas. DHS plans to recognize excellent Plan performance through performance incentives (financial and/or non-financial).

B. Contractual Obligations. If a plan does not meet its contractual obligations and has failed to achieve the MPLs in one or more HEDIS measures, it will be required to submit a corrective action plan and/or be sanctioned in accordance with contract requirements and applicable regulations.

DISCUSSION

EXTERNAL QUALITY REVIEW ORGANIZATION'S RESPONSIBILITY

Effective January 1, 1999, the External Quality Review Organization's (EQRO) responsibilities include the following:

A. The Consumer Assessment of Health Plans Study (CAHPS) 2.0-H.
In 1999, for the Two Plan Model Plans, Sacramento GMC Plans, and the COHS Plans, the EQRO will conduct a consumer survey using CAHPS 2.0-H. The Plans will cooperate with the EQRO in all aspects of the implementation of this survey by providing an extract of their member information.

B. NCQA HEDIS Compliance Audit for the External Accountability Set
The EQRO will conduct HEDIS compliance audits on all Plans, except those who, in 1999, selected another NCQA-Licensed Audit Organization at their own cost.

C. Annual Evaluation of Plans' IQIPs
The EQRO will be responsible for evaluating all IQIPs. The EQRO will evaluate the IQIPs in accordance with the fifteen IQIP key reporting elements. The EQRO will submit their IQIP reviews to the Plans after a maximum period of thirty calendar days upon receipt of the Plan's IQIP.

If you have any questions regarding this policy letter, please contact the DHS EQRO Project Coordinator.

Sincerely,

Susanne M. Hughes
Acting Chief
Medi-Cal Managed Care Division

Enclosure

bcc: Shughes, MFermazin, RRecostodio, MHinojosa,

SH:bjh

W:CLERICAL/QIS/EQRO/QIPOLICYLTR_final

Enclosure A

Summary of Quality Improvement Requirements

Topic Area	Requirement	Report Date	Distribution of Reports
External Accountability Set HEDIS Measures	Plans submit the name of the NCQA-Licensed Audit Organiation	2nd week of Jan.	Simultaneously send two copies to the Office of Clinical Standards and Quality and one copy to EQRO.
	Plans will submit Section A of BAT (Introductory Section) if EQRO is not used as the auditor	1st week of March	Same as above
	1. Childhood Immunization Status (for 2 year olds) 2. Well Child Visits in the first 15 months of life 3. Well Child Visits in the 3rd, 4th, 5th, and 6th Year 4. Adolescents Well-Care Visits 5. Initiation of Prenatal Care 6. Prenatal Care in the 1st Trimester 7. Check-ups after delivery (COHS will replace Well-Care Visits for ages 3-6 with Diabetic Retinal Exam measure.)	10/1/99 (Report date for subsequent years as determined by DHS)	Same as above
Quality Improvement Collaborative Initiative (QICI)	Common Topic, standardized study methodology to produce comparable, reliable and credible results	10/1/99	Same as above
Internal Quality Improvement Projects (IQIP)	1999-2000 2 clinical topic areas 2 non-clinical areas		
	Initial Report – Key Reporting Elements 1-6	10/1/99	Same as above
	Phase 1 -- Key Reporting Elements 1-8	12/1/99	Same as above
	Phase 2 -- Key Reporting Elements 1-9		Same as above
	Phase 3 -- Key Reporting Elements 1-13		Same as above
	Phase 4 -- Key Reporting Elements 1-14		Same as above
	Final Report -- Key Reporting Elements 1-15		Same as above
	Phase Progress Reports	Annual	Same as above

DRAFT Enclosure B

DHS Required Sampling Method for Medi-Cal Health Plans

The table below shows the minimum sample sizes necessary to achieve a 95% confidence level with a 5% error tolerance based on HEDIS systematic sampling applicable to the reporting year. The minimum sample size is a function of the confidence level, the error that one is willing to tolerate in estimating the true population value, and the actual distribution of the variable in the population.

County	Eligible Cases	Proportional Systematic	HEDIS 1999 Sample Size
A	60.000	247	NA
B	20,000	82	NA
C	10,000	41	NA
D	8,000	33	NA
E	2,000	8	NA
Total	100,000	411	411

Health Plan XYZ has 100,000 eligible children two years of age in the five counties. HSAG, with NCQA approval, will use a proportional systematic sampling scheme. Using this method, the sample would represent the Health Plan XYZ and any one county would not disproportionately bias the results at the plan level. The proposed method is as follows:

1. Determine eligible population per HEDIS 1999 Technical Specifications.

2. Determine proportion of eligible population in each county.

3. Apply proportion to the required sample size per HEDIS. In the above table, 60 % x 411 = 247, 20 % x 411 = 82 ... 2 % x 411 = 8. This becomes the required sample size per county.

4. Sort by county first, then alphabetize by member's name.

5. Apply systematic sampling (as specified in HEDIS 1999) to each county using the required sample size as given above (step #3).

In the above table, County A comprises 60% of Health Plan XYZ while county E only comprises two percent. Using a straight systematic sampling could result in an over or under sampling of county E. The proposed methodology is bias proportional sampling using the systematic method to actually select the cases. In affect, each county is treated as a separate Health Plan, systematic sampling is performed, and then the cases are combined to form the full HEDIS sample of 411 cases.

DRAFT

Enclosure C

COMPONENTS OF AN INTERNAL QUALITY IMPROVEMENT PROJECT

IQIP are part of a comprehensive quality improvement program that addresses the quality of clinical care as well as the quality of health services delivery. A project is an initiative by the organization to measure its own performance in major focus areas of clinical care and non-clinical care.

Clinical/Non-Clinical Designation

Self-explanatory.

Project Name

Self-explanatory.

Project Questions/Hypothesis

Project Questions/Hypothesis must be clearly stated. These set the framework for data collection, analysis and interpretation.

Background and Purpose of the Project

Plan must detail how the proposed project is relevant to the enrolled population; how the Plan has the ability to impact performance in the selected project area and what the relative size of the membership population addressed by the project is.

Clinical Description and Related Clinical Guidelines

Practice guidelines are systematically developed statements based on accepted medical evidence that assist practitioner and patient decisions about appropriate health care for specific clinical circumstances. They can be used to objectively evaluate a plan's specific clinical and health service delivery issues as well as guide care delivery.

Performance Goals and Benchmarks for each Quality Indicator

Goals are predetermined desired levels of performance on indicators. Benchmarks are the industry measure of best performance.

Project Timeline

Plans must develop a work plan describing projected timelines for completion of each phase of the project.

Research Design/Project Methodology

The research design will include, but is not limited to, the following:

a) at risk population for each quality indicator
b) data sources to be used
c) who will collect the data
d) dates of service to be studied
e) data validation techniques
f) how study quality indicators are to be calculated
g) measurement tools to be used
h) how study data confidentiality will be maintained
i) audience findings will be communicated to
j) re-measurement plan.

Data Collection

Active collection of baseline project indicator data has begun. Once data collection has begun, the plan should not allow any changes to be made in the data collection methodology.

Data Analysis

Includes both descriptive and statistical analysis techniques. Clear presentation of meaningful key data and study results.

Comparative Analysis

Comparison of Plan quality indicator findings to local, regional, and national findings.

Interpretation of Findings (includes limitations and barriers of study)

The Plan needs to appropriately interpret key findings and attribute results to likely causes. If outcome indicators are studied, the difficulty of attributing outcomes to health care received must be addressed.

Action/Improvement Plans

The study must include the reporting to a Quality Improvement Committee and/or a Governing Body.

Re-measurement Data Analysis

Includes both descriptive and statistical analysis techniques. Clear presentation of meaningful key data and study results.